MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23)

CERTIFICATE OF DEATH

06421

Reg. Dist. No. 333

1. PLACE OF DEATH

County: Wicomico

City or town: Rockawalkin
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 42 years

Hospital, Institution, or street address where death occurred: Rockawalkin

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Wicomico

City or town: Rockawalkin
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mary Elizabeth Atkinson

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	married

6.(b) Name of husband or wife: Robert J. Atkinson

6.(c) If alive, give age 73 years

7. Birth date of deceased (mo., day, yr.): June 19, 1872

8. AGE: Years	Months	Days	If less than one day
72	11	23	hrs. min.

9. Birthplace: Somerset Co, Md
(Town, county, and state)

10. Usual occupation: At Home

11. Industry or business

FATHER
12. Name: Littleton Maddox
13. Birthplace: Worcester Co, Md

MOTHER
14. Maiden name: Lydia Long
15. Birthplace: Somerset Co, Md

16. Informant: Robert J. Atkinson
Address: Hebron, Md, R.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6/13/45 (month) (day) (year)

Cemetery or crematory: Parsons cemetery

Location: Salisbury, Md

18. Funeral director: The Hill & Jackson

Address: Salisbury Md

19. 6/13 1945 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 11 1945; at 7.20 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1st 1945, to June 11. 1945

and that I last saw h[illegible] alive on June 11 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to	
Due to	
Other conditions Chronic Myocarditis	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: William Emerick M. D. or other

Address: Hebron - Md Date signed June 12-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

06430

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1170)

CERTIFICATE OF DEATH

★ Reg. Dist. No. 333

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Wicomico

City or town Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Peninsula General Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Del. County Sussex

City or town Lincoln

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Walter S. Berwick

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	white	widowed

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 29, 1865

8. AGE: Years 79 | Months 10 | Days 8 | If less than one day hrs. min.

9. Birthplace Buckingham (Town, county and state)

10. Usual occupation Retired

11. Industry or business

FATHER 12. Name Wm. Berwick

13. Birthplace England

MOTHER 14. Maiden name no recd

15. Birthplace

16. Informant James Berwick

Address Lincoln, Del.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7-1-45 (month) (day) (year)

Cemetery or crematory Lincoln Cem., Lincoln, Del.

Location Lincoln, Del.

18. Funeral director D. A. Berry Jr.

Address Milford, Del.

19. 6/29/45 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 28 19 45, at 7:32 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 24 19 45, to June 28 19 45 and that I last saw h. i. m. alive on June 28 19 45

Immediate cause of death Cardiac Thrombosis (Rt. Auricle) — DURATION

Due to

Due to

Other conditions Perforated Peptic Ulcer, Acute Hemorrhagic Pancreatitis

(Include pregnancy within 3 months of death)

Major findings of operation none — Date of op.

Autopsy results See Above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE Rivers Hayson M.D.

M.D. or other

Address Salisbury, Md. Date signed 6/29/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (Md)

06431

CERTIFICATE OF DEATH

Reg. Dist. No. 333

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH

County: Wicomico

City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 34 years

Hospital, Institution, or street address where death occurred: 109 Fitzwater St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md County: Wicomico

City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town)

Street No. 109 Fitzwater St (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Andrew J. Booth

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Estelle Booth

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): June 3, 1869

8. AGE: Years	Months	Days	If less than one day
76	0	22	____ hrs. ____ min.

9. Birthplace: Virginia (Town, county, and state)

10. Usual occupation: Retired carpenter

11. Industry or business

FATHER — 12. Name: Not Known

13. Birthplace

MOTHER — 14. Maiden name: Not Known

15. Birthplace

16. Informant: Wicomico Welfare Board

Address: Salisbury, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6/27/45 (month) (day) (year)

Cemetery or crematory: John Wesley Cemetery

Location: Mt. Vernon Md

18. Funeral director: The Hill & Johnson Co

Address: Salisbury, Md

19. 7/6/45 (Date rec'd by registrar) Harriet E. Johnson (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 25 1945, at 7:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 20 1945, to June 25 1945 and that I last saw h... alive on June 25 1945

Immediate cause of death	OURATION
Coronary Occlusion	2 hrs
Due to: Chr. Val. Heart	2 yrs
Due to: Hypertension	2 yrs
Other conditions: Arteriosclerosis	5 yrs

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: ____ Injured at work?

23. SIGNATURE: H O Davis M D (M. D. or other)

Address: Hunters Rest Md Date signed 6/27/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (832)

CERTIFICATE OF DEATH

06432

Reg. Dist. No. 330

1. PLACE OF DEATH:

County: Wicomico

City or town: Mardela Springs - Rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:
Near San Domingo

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Wicomico

City or town: Mardela Springs - Rural
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Near San Domingo
(If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME: Arthur H. Brown

3.(b) Social Security Number: 218-09-1791

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Annie E. Brown

6.(c) If alive, give age: 60 years

7. Birth date of deceased (mo., day, yr.): February 12, 1882

8. AGE:

Years	Months	Days	If less than one day
63	4	13	...hrs. ...min.

9. Birthplace: Wicomico County, Maryland (Town, county, and state)

10. Usual occupation: Day Laborer

11. Industry or business: Farm

FATHER
12. Name: George Brown
13. Birthplace: Wicomico County, Maryland

MOTHER
14. Maiden name: Mary Hubbard
15. Birthplace: Wicomico County, Maryland

18. Informant: Mrs. Annie E. Brown
Address: Mardela Springs, Maryland, R.F.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 29 1945 (month) (day) (year)

Cemetery or crematory: San Domingo Cemetery

Location: Near Sharptown, Maryland

18. Funeral director: J. J. Frampton and Son

Address: Fredericksburg, Maryland

19. 6/29/45 (Date rec'd by registrar) 19... W. H. Robertson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 25 1945, at 1 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3/1 1945, to 6/25 1945

and that I last saw h. him alive on 6/25/45 19...

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to: Arteriosclerosis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE: Charles M. Moyer M.D.
M. D. or other

Address: Salisbury, Md. Date signed: 6/28/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (167)

CERTIFICATE OF DEATH

(6433

★ Reg. Diat. No. 329

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Peninsula General Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Wicomico

City or town: Delmar
(If outside city or town limits, write RURAL and give nearest town)

Street No. R 7 D # 3
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Warren Bruce

3.(b) Social Security Number: 088-09-1689

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mary Bruce

6.(c) If alive, give age: 28 years

7. Birth date of deceased (mo., day, yr.): Oct 22 - 1907

8. AGE: Years: 37 | Months | Days | If less than one day: hrs. min.

9. Birthplace: Haverhill, Mass. (Town, county, and state)

10. Usual occupation: Brakeman

11. Industry or business: Railroad

FATHER — 12. Name: Donald M. Bruce

FATHER — 13. Birthplace: Nova Scotia - Canada

MOTHER — 14. Maiden name: Ellen E. Powers

MOTHER — 15. Birthplace: Sandwich Mass.

18. Informant: Mary Bruce

Address: Delmar, Del R7D3

17. Cremation (Burial, cremation, or removal. Which?) Date thereof 6-4-45 (month) (day) (year)

Cemetery or crematory: Hall Way Pond

Location: Plymouth Mass.

18. Funeral director: W. S. Gravel Co

Address: Delmar, Del

19. 6/2/45 (Date rec'd by registrar) — Harriet E. Johnson, Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 2, 1945 at 6 45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 19 45 to June 2 19 45 and that I last saw him alive on June 1 19 45

Immediate cause of death	DURATION
Shock	6 hrs
Due to: Traumatic amputation of R arm & R leg	6 hrs
Due to:	
Other conditions: Fracture of lacerations of head & possible internal injury	7

(Include pregnancy within 3 months of death)

Major findings of operations: as above

Date of op.

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accident Date of 6-1-45

Where did injury occur? Delmar (City or town) Wicomico (County) Del (State)

Injured at home, farm, industry, public place (where?) R.R. yard

Means of injury: Fell off box car injured at work? yes
under train

23. SIGNATURE: [illegible] M.D. or other

Address: Salisbury, Md. Date signed 6-2-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH INDELIBLE INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Evidence for change of age of deceased is shown on FILM No. G96 JUL 12 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

06434

Reg. Dist. No. 333

1. PLACE OF DEATH: County: Wicomico Co. City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? Hospital, institution, or street address where death occurred: 415 Dans St. How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State: Md. County: Wicomico Co. City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town) Street No.: 415 Dans St. (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Daniel Carter

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: No. never

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 16 1871

8. AGE: Years	Months	Days	If less than one day
74 64	0	2	..... hrs. ..... min.

9. Birthplace: Somerset Co. Md. (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER — 12. Name: George Carter

FATHER — 13. Birthplace: Somerset Co. Md

MOTHER — 14. Maiden name: Leah Nicey Adkins

MOTHER — 15. Birthplace: Somerset Co. Md.

16. Informant: Miss Allie Carter

Address: Snow Hill Md.

17. Buried (Burial, cremation, or removal. Which?) Date thereof June 20-45 (month) (day) (year)

Cemetery or crematory: Parsons Cem.

Location: Salisbury Md.

18. Funeral director: Holloway & Co. Walter R. Holloway

Address: Salisbury Md.

19. 6/20/45 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 18th 1945, at 11 a. M

21. I CERTIFY that death occurred on the date above stated: (that) I attended deceased from May 20 1945 to June 18 1945 and that I last saw h... alive on June 18 1945

Immediate cause of death	DURATION
Chr. Valv. Heart	2
Due to: Chr. Int. Nephritis	2 1
Due to: Hypertension	2 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: H. O'Day M.D.

M. D. or other

Address: Princess Anne Md. Date signed 6/19/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (183)

CERTIFICATE OF DEATH

L6435

Reg. Dist. No. 333

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? One year

Hospital, Institution, or street address where death occurred: no

How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Wicomico

City or town: Salisbury md

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION) no

2.(a) If veteran, name war

3. (a) FULL NAME Abraham Cole

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	a a	married

6.(b) Name of husband or wife: Clara Lee Cole

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): about 1922

8. AGE: Years	Months	Days	If less than one day
about 23	—	—	..... hrs. ..... min.

9. Birthplace: Salisbury Md. (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Same as above

FATHER — 12. Name: Unknown

FATHER — 13. Birthplace: unknown

MOTHER — 14. Maiden name: Virginia Cole

MOTHER — 15. Birthplace: Salisbury Md.

16. Informant: Edgar B. Jones

Address: Hurlland md

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 19, 1945 (month) (day) (year)

Cemetery or crematory: Salisbury

Location: Salisbury Md.

18. Funeral director: James H. Stewart

Address: Salisbury md

19. 6/18/45 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 15 19 45, at 4 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 9 19 to June 15 19 45

and that I last saw h[illegible] alive on June 15 19 45

Immediate cause of death	DURATION
Drowning	Sudden death
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accident Date of 6-15-45

Where did injury occur? Salisbury (City or town) Wicomico (County) Md. (State)

Injured at home, farm, industry, public place (where?) Johnson's Lake

Means of injury: Drowned while swimming Injured at work? No

23. SIGNATURE: For Raymond Wood M.D.

M. D. or other

Address: Salisbury Md Date signed 6/18/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

06436

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:
County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: Peninsula General Hospital
How long in hospital or institution? 5 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Worcester
City or town Snow Hill Maryland
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war no ✓

3.(a) FULL NAME Charles Collins

3.(b) Social Security Number 218-06-8853-7

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	C	

6.(b) Name of husband or wife Ethel Collins
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) about 1882

8. AGE: Years	Months	Days	If less than one day
about 53			hrs. min.

9. Birthplace Snow Hill Worcester Co. Maryland
(Town, county, and state)
10. Usual occupation Laborer
11. Industry or business Same
FATHER 12. Name Don't know
13. Birthplace " "
MOTHER 14. Maiden name Don't know
15. Birthplace " "
16. Informant Mrs. Lynch
Address Ocean City
17. Burial (Burial, cremation, or removal. Which?) Date thereof 6-9-45 (month) (day) (year)
Cemetery or crematory Holmes
Location Snow Hill, Maryland
18. Funeral director James F. Stewart
Address 402 E. Church St. Salisbury Md
19. 6/9 1945 Harold E. Johnson Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 6 1945 at 4:17 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
19 , to 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE M. D. or other
Address Salisbury Date signed 6/9/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

66437

Reg. Dist. No. 332

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH: Wicomico Co

County

City or town: Pittsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 years

Hospital, institution, or street address where death occurred: R.D. #2

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Wicomico Co

City or town: Pittsville

(If outside city or town limits, write RURAL and give nearest town)

Street No.: R.D. #2

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Thomas Burton Chandler

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Jennie C. Chandler

6.(c) If alive, give age: 46 years

7. Birth date of deceased (mo., day, yr.): Jan. 31 - 1882

8. AGE: Years: 63 | Months: 4 | Days: 22 | If less than one day: ...hrs. ...min.

9. Birthplace: Millsboro Delaware (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: Own Farm

MOTHER

12. Name: Hiram Chandler

13. Birthplace: Sussex Co. Delaware

FATHER

14. Maiden name: Jennie Brittingham

15. Birthplace: Sussex Co. Delaware

16. Informant: Mrs. Jennie C. Chandler

Address: R.D. #2 Pittsville Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 26-45 (month) (day) (year)

Cemetery or crematory: St. Johns Cem.

Location: Powellville Maryland

18. Funeral director: Holloway & G. Walter R. Wilson

Address: Salisbury Maryland

19. 6/26 1945 (Date rec'd by registrar) Lillian R. Davis Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 22nd 1945 at 10 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 28 1945 to June 22 1945 and that I last saw him alive on June 18 1945

Immediate cause of death	DURATION
Congestive Heart failure	1 year
Due to: Arteriosclerosis	5 yr.
Due to: Cardiovenal Vascular disease	10 yr.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ...Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: ...Injured at work?

23. SIGNATURE: Robert L. La Mar, M.D. M. D. or other

Address: Powellville Md. Date signed 6-23-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

★6438

Reg. Dist. No. 303

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 13 days
Hospital, Institution, or street address where death occurred: Salisbury Peninsula General Hosp.
How long in hospital or institution? 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Worcester
City or town Pocomoke City Md,
(If outside city or town limits, write RURAL and give nearest town)
Street No. —
(If rural, give LOCATION)
2.(a) If veteran, name war — ✓

3. (a) FULL NAME Bertie H. Corbett

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	Widowed

6.(b) Name of husband or wife: William E. Corbett
6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.): January 17, 1884

8. AGE: Years: 61 | Months: 5 | Days: 3 | If less than one day: hrs. min.

9. Birthplace: Virginia (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: —

FATHER
12. Name: David H. Foster
13. Birthplace: Unknown

MOTHER
14. Maiden name: Mamie L. Layfield
15. Birthplace: Md.

16. Informant: Arthur McDaniel
Address: Pocomoke City Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 24 1945 (month) (day) (year)
Cemetery or crematory: St Marys Episcopal Cem
Location: Pocomoke City Md
18. Funeral director: Marguerite H. Watson
Address: Pocomoke City Md.

19. 6/24/45 (Date rec'd by Registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 20th 1945, at 9.05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6/8 1945, to 6/20 1945; and that I last saw her alive on 6/19 1945

Immediate cause of death	DURATION
Carcinoma of Uterus	6 mos.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Extensive carcinoma of Uterus & metastases. Date of op. 6/18/45
Autopsy results: none.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Olan T. Tyndall M.D. M. D. or other
Address: Salisbury, Md. Date signed 6/20/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

06441

Reg. Dist. No. 337

1. PLACE OF DEATH:

County Wicomico

City or town Nanticoke

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Wicomico

City or town Nanticoke

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Lora Barkley Dashield

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	col.	married

6.(b) Name of husband or wife James E. Dashield

6.(c) If alive, give age 75 years

7. Birth date of deceased (mo., day, yr.) Nov 30 1872

8. AGE: Years	Months	Days	If less than one day
72	6	4	hrs. min.

9. Birthplace Eyesbury (Town, county, and state)

10. Usual occupation Housework

11. Industry or business

FATHER 12. Name William P. Nuttter

FATHER 13. Birthplace Nanticoke

MOTHER 14. Maiden name Lora Nuttter

MOTHER 15. Birthplace Nanticoke

16. Informant James E. Dashield

Address Nanticoke

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 6, 1945 (month) (day) (year)

Cemetery or crematory cemetery

Location Jesterville

18. Funeral director L. P. Messersmith

Address Pittsburg Md

19. June 6 1945 (Date rec'd by registrar) R. Wofford Walter Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 4 1945 at 12:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 29 1945 to May 29 1945 and that I last saw h alive on 19

Immediate cause of death	DURATION
Coronary Thrombosis	1 wk.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE D. Allen Dills M. D. or other

Address Nanticoke Md Date signed 6-5-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-a)

CERTIFICATE OF DEATH

0643

Reg. Dist. No. 333

1. PLACE OF DEATH:

County: Wicomico

City or town: Fruitland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, Institution, or street address where death occurred: no

How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Wicomico

City or town: Fruitland

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Hatch

(If rural, give LOCATION) no

2.(a) If veteran, name war:

3. (a) FULL NAME Rosa E. Dashiell

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	a.a.	widow

6.(b) Name of husband or wife: David Dashiell

Dead 6.(c) If alive, give age no years

7. Birth date of deceased (mo., day, yr.) about 1882

8. AGE: Years	Months	Days	If less than one day
about 63			hrs. min.

9. Birthplace: Fruitland (Town, county, and state)

10. Usual occupation: Housekeeper

11. Industry or business: Domestic

FATHER 12. Name: Unknown

13. Birthplace: unknown

MOTHER 14. Maiden name: Martha Noble

15. Birthplace: Allen md

16. Informant: Mrs. Alene Purnell

Address: Salisbury md

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 5 - 1945 (month) (day) (year)

Cemetery or crematory: Mt. Calvery

Location: Fruitland Md

18. Funeral director: James H. Stewart

Address: Salisbury md

19. 6/4/45 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 5, 1945, at 5A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 20 1944, to June 1, 45

and that I last saw h... alive on June 1, 1945

Immediate cause of death	DURATION
Coronary Thrombosis	4 days
Due to: Chr. Hart Disease	2 yrs
Due to: Arter Sclerosis	7 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: M.D.

M. D. or other

Address: Fruitland Date signed 6/4/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06440

Reg. Diat. No. 333

1. PLACE OF DEATH:
County: Accomack
City or town: Onancock (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 13 Days
Hospital, institution, or street address where death occurred:
Tunnell General Hospital
How long in hospital or institution? 13 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Del. County: Sussex
City or town: Laurel (If outside city or town limits, write RURAL and give nearest town)
Street No.: Park Street (If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Rowland Oakley Davis

3. (b) Social Security Number: 222-01-0577

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feby 15 1917

8. AGE: Years: 33 | Months: 4 | Days: 8 | If less than one day: hrs. min.

9. Birthplace: Va. (Town, county, and state)
10. Usual occupation: R.R. Employee
11. Industry or business:

FATHER
12. Name: Oakley Davis
13. Birthplace: Va.

MOTHER
14. Maiden name: Unknown
15. Birthplace:

16. Informant: Mamie Davis
Address: Laurel Del.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 27. 45 (month) (day) (year)
Cemetery or crematory: Cemetery at
Location: Millsboro Del.
18. Funeral director: J. Harvey Willeman
Address: Federalsburg, Md.

19. 6/27/45 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 23 1945 at 7.50 P.M.

21. I CERTIFY that death occurred on the date above stated: ~~that I attended deceased from~~ 19 to 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
Rupture of Spleen due to accident	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of 6/23/45
Where did injury occur? near Princess Anne (City or town) Somerset (County) Md (State)
Injured at home, farm, industry, public place (where?) Public place
Means of injury: auto accident Injured at work? No

23. SIGNATURE: Wm H. Lankford M.D. M. D. or other
Address: Princess Anne Md Date signed 6/27/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93)

CERTIFICATE OF DEATH

06442

Reg. Dist. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 25 years
Hospital, Institution, or street address where death occurred: 105 Cherry street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. 105 Cherry street
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: John J. Doran

3.(b) Social Security Number

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Single
6.(b) Name of husband or wife
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): Dec. 25-1872

8. AGE: Years: 72 Months: 5 Days: 21 If less than one day: ..... hrs. ..... min.

9. Birthplace: Catonsville Md. (Town, county, and state)
10. Usual occupation: Engineering asst.
11. Industry or business: Public Utilities

FATHER
12. Name: Patrick Doran
13. Birthplace: Ireland

MOTHER
14. Maiden name: Rose Bynne
15. Birthplace: Ireland

16. Informant: M. C. Norman Davis
Address: Salisbury Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 19-1943 (month) (day) (year)
Cemetery or crematory: New Cathedral Cem.
Location: Catonsville, Maryland
18. Funeral director: Hillman & Co. Walter R. Hillman
Address: Salisbury Maryland.

19. 6/17/1943 (Date rec'd by registrar) Edward E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 16 1943 at 10 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1943 19.. to June 16 1943
and that I last saw h.. alive on June 12 1943

Immediate cause of death	OURATION
Chronic myocarditis	3 yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: ..... Injured at work?

23. SIGNATURE: J. Norman M. D.
M. D. or other
Address: Salisbury md. Date signed 6/18/43

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (17c)

CERTIFICATE OF DEATH

06443

Reg. Dist. No. 333

1. PLACE OF DEATH:
County: ~~Wicomico~~ Worcester
City or town: Salisbury Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 hours.
Hospital, institution, or street address where death occurred: Penin. Gen. Hospital
How long in hospital or institution? 6 hrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Worcester
City or town: Near Snow Hill Rural #2
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: No ✓

3.(a) FULL NAME: Doris A Figgs

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 10 - 1930

8. AGE: Years 15 | Months 0 | Days 29 | If less than one day: hrs. min.

9. Birthplace: Near Snow Hill Md (Town, coooty, and state)

10. Usual occupation: School girl

11. Industry or business: —

FATHER
12. Name: George Figgs
13. Birthplace: Maryland

MOTHER
14. Maiden name: Gertrude Bryday
15. Birthplace: Maryland

16. Informant: Mrs Geo W. Figgs
Address: Snow Hill Md Rural #2

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 12 45 (month) (day) (year)
Cemetery or crematory: Mt Olive
Location: Snow Hill Rural

18. Funeral director: Hearne & Dennis
Address: Snow Hill Md

19. 6/12, 1945 (Date recd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 9 1945 at 6.55a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Hemorrhage due to	
Cuts in auto accident	6 hrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accident Date of June 8 45
Where did injury occur? Near Dividing Worcester Md
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?): Highway No 113
Means of injury: Auto accident Injured at work? No

23. SIGNATURE: John L. Riley Dep. Med Examr
M. D. or other
Address: Snow Hill Md Date signed: 6/9/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (74a)

CERTIFICATE OF DEATH

06444

Reg. Dist. No. 335

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Kingsmico
City or town: Sharptown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 50 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Wic
City or town: Sharptown
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Annie J. Fletcher

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	White	Widow

6.(b) Name of husband or wife: Thomas Fletcher
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan 14 - 1868

8. AGE: Years 77 | Months 5 | Days 7 | If less than one day: hrs. min.

9. Birthplace: Near Sharptown (Town, county, and state)
10. Usual occupation: House work
11. Industry or business
FATHER 12. Name: Henry K. Phillips
13. Birthplace: Del.
MOTHER 14. Maiden name: Margie Cooper
15. Birthplace: Del
16. Informant: Henry Fletcher
Address: 616 Erie St Camden N.J.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 6 24 1945 (month) (day) (year)
Cemetery or crematory: Taylor
Location: Sharptown
18. Funeral director: Graham or Bros
Address: Sharptown Md
19. Jun 27 1945 (Date rec'd by registrar) Wallace H Mann Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 21 1945 at 1-30 AM
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1945 to June 21 1945
and that I last saw her alive on June 21 1945
Immediate cause of death: Chronic Nephritis — DURATION 2 hours
Due to: Hypertension — 5 Ma Years
Due to:
Other conditions: Cerebral Hemorrhage — DURATION Dec 1944
(Include pregnancy within 3 months of death)
Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: N. S. Kuchman M.D. M. D. or other
Address: Sharptown Md Date signed: 6/27/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

CERTIFICATE OF DEATH

06445

Reg. Dist. No. 733

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: Peninsula General Hospital
How long in hospital or institution? 11 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. 103 Zion St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Mrs. Lucy Fowler.

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	W	Married

6.(b) Name of husband or wife: Bertie K. Fowler
6.(c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.): July 15-1887

8. AGE: Years 57 | Months 11 | Days 12 | If less than one day: hrs. min.

9. Birthplace: Wicomico Co. Md.
(Town, county, and state)

10. Usual occupation: Home wife at Home

11. Industry or business

FATHER
12. Name: Edward J. Moore
13. Birthplace: Wico. Co. Md

MOTHER
14. Maiden name: Theodosia Bivins
15. Birthplace: Wico. Co. Md.

18. Informant: Mr. Bertie K. Fowler
Address: 103 Zion St. Salisbury Md

17. Burial (Burial, cremation, or removal? Which?) Date thereof: June 29-45 (month) (day) (year)
Cemetery or crematory: Parsons Cem.
Location: Salisbury Md.

18. Funeral director: Holloway & Co. Walter R. Holloway
Address: Salisbury Maryland.

19. 6/27/45 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 27- 1945 at 8 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1945, to June 27 1945 and that I last saw her alive on June 27 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	48 hours
Due to: Hypertensive Cardio-Vascular Disease	"
Due to:	
Other conditions: Diabetes Mellitus + Diabetic Gangrene	"

(Include pregnancy within 3 months of death)

Major findings of operations: Autopsy
Date of op.
Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

~~22~~. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Rivers Haugon, M. D.
M. D. or other
Address: Salisbury, Md. Date signed: 6/27/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

STATE OF MARYLAND—CERTIFICATE OF DEATH 06446

1. PLACE OF DEATH (18a)

County Wicomico, Registration Dist. No. 332

Village or City Pittsville, Md. No. St., Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U.S. if of foreign birth? yrs. mos. ds.

2. FULL NAME Martha Ellen Freeny. If U. S. Veteran, specify WAR

(a) Residence: No. St., Ward.
(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Female	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of J. R. Freeny.

6. DATE OF BIRTH (month, day, and year) June 9th 1871

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
74	—	6	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. House work.

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Date deceased last worked at this occupation (month and year) 1944

11. Total time (years) spent in this occupation Life

12. BIRTHPLACE (city or town) Near Shorella, Md.
(State or country)

FATHER

13. NAME Isaac Truitt.

14. BIRTHPLACE (city or town) Pittsville, Md.
(State or country)

MOTHER

15. MAIDEN NAME Jane Brittingham.

16. BIRTHPLACE (city or town) Near Millsboro, Delaware
(State or country)

17. INFORMANT J. R. Freeny
(Address) Pittsville, Md.

18. BURIAL, CREMATION, OR REMOVAL
Place Grace Cemetery Date June 17, 1945

19. UNDERTAKER Wm. Howard Wellst
(Address) Pittsville, Md.

20. FILED 6/17, 1945 Lillian V. Davis
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH June (Month) 15th (Day), 1945 (Year)

22. I HEREBY CERTIFY, That I attended deceased from 6-1-45, 19, to day of death
I last saw her alive on 6-15-45, 19; death is said to have occurred on the date stated above, at 9-5 a m,

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
Broncho-pneumonia	6-12-45
Other Contributory Causes of importance: Fractured Femur,	
Due to Accidental fall on C. & O. R. R.	

Name of operation None Data of

What test confirmed diagnosis? Clinical Was there an autopsy? No.

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Accident Date of Injury May 9th, 1945

Where did injury occur? Pittsville, Wicomico County, Maryland
(Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE. At her home.

Manner of Injury Accidental fall

Nature of Injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) Frank J. Lewis M. D.

(Address) Hallwood, Md.

V. S. No. 1

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I		Example II	
The principal cause of death and related causes of importance were as follows:	Date of onset	The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*	*Attack of epilepsy*	*1 week ago*
Chronic interstitial nephritis	*1921*	*Run over by street car*	*1 week ago*
Cerebral hemorrhage	*July 5, 1927*	*Peritonitis*	*3 days ago*
Other contributory causes of importance:		Other contributory causes of importance:	
Gallstones	*May 1, 1923*	*Gastroenteritis*	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (32)

CERTIFICATE OF DEATH

06447

Reg. Dist. No. 393

1. PLACE OF DEATH:

County Wicomico

City or town Salisbury Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Peninsula General Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Wicomico

City or town Mardela, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Graham, Mrs William A.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	Widowed

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 22 1869

8. AGE: Years 75 | Months 10 | Days 14 | If less than one day hrs. min.

9. Birthplace Md (Town, county, and state)

10. Usual occupation Retired Farmer

11. Industry or business

FATHER 12. Name James Graham

13. Birthplace Md

MOTHER 14. Maiden name Mary Huston

15. Birthplace Md

16. Informant Hilda Evans

Address Mardela

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6-7-1945 (month) (day) (year)

Cemetery or crematory Mardela

Location

18. Funeral director Graveno Bros

Address Sharptown

19. 6/7/45 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/5 1945, at 1210 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5/30 1945 to 6/5 1945

and that I last saw him alive on 6/5 1945

Immediate cause of death	DURATION
Chronic Myocarditis	Years
Due to	
Due to	
Other conditions Hypertension Pneumonia	Weeks

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide NC Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. H. Heck M. D. or other

Address Salisbury Date signed 6/6/45

VS A15

PLEASE WRITE PLAINLY, WITH (illegible) DING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06448

Reg. Dist. No. 333

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Since Jan. 5, 1944

Hospital, institution, or street address where death occurred:
Eastern Shore Tb. Sanatorium

How long in hospital or institution? Since Jan. 5, 1944

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Caroline

City or town: Denton, Maryland
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war: No ✓

3.(a) FULL NAME: Dolores Estella Griffith

3.(b) Social Security Number: 141-16-6215

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 18, 1923

8. AGE: Years	Months	Days	If less than one day
22	2	23	..... hrs. ..... min.

9. Birthplace: Baltimore City, Maryland
(Town, county, and state)

10. Usual occupation: Waitress

11. Industry or business

FATHER
12. Name: Olin Griffith
13. Birthplace: Maryland

MOTHER
14. Maiden name: Margaret Wheeler
15. Birthplace: Maryland

16. Informant: Deceased
Address

17. Buried (Burial, cremation, or removal. Which?) Date thereof June 14-45 (month) (day) (year)
Cemetery or crematory Cathedral Cem
Location Baltimore, Maryland

18. Funeral director: Collins & G. Walter R. Allen
Address Salisbury, Maryland.

19. 6/11, 1945 (Date rec'd by Registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 11, 1945 at 8:45a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1/5/45, 19..., to 6/11/45, 19...
and that I last saw her alive on 6/11/45, 19...

Immediate cause of death: Pulmonary Tuberculosis — DURATION

Due to: — DURATION

Due to: — DURATION

Other conditions: — DURATION

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Paul Lee M.D. M. D. or other

Address: Salisbury, Md. Date signed: 6/11/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

(M)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(T)

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

0644)

★ Reg. Diat. No. 11-336

1. PLACE OF DEATH:

County: Prince

City or town: Del Rand

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 81 yrs.

Hospital, Institution, or street address where death occurred: 500 Chestnut St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Mercer

City or town: Delmar

(If outside city or town limits, write RURAL and give nearest town)

Street No. 500 Chestnut

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Edith May Hastings

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Feb 3- 1864

8. AGE: Years	Months	Days	If less than one day
81			____ hrs. ____ min.

9. Birthplace: Wicomico County, Md (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: Home

FATHER — 12. Name: Elzie Beal Hastings

FATHER — 13. Birthplace: Wicomico Co. Md

MOTHER — 14. Maiden name: Mary E. Hastings

MOTHER — 15. Birthplace: Salisbury Co- Del

16. Informant: Mr. E. M. Hastings

Address: Delmar Del

17. Burial (Burial, ~~cremation, or removal~~. Which?) Date thereof 6-30-45 (month) (day) (year)

Cemetery or ~~crematory~~: M. P.

Location: Delmar, Del

18. Funeral director: W-S Funeral Co

Address: Delmar Delaware

19. June 30 1945 (Date rec'd by registrar) Harry E Hudson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 28 1945, at 8 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 15 1945, to June 28 1945

and that I last saw h. alive on June 25 1945

Immediate cause of death	DURATION
Uremic Coma	2 days
Due to Chronic Nephritis	3 yrs
Due to Arteriosclerosis	6 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results: ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury: ____ Injured at work?

23. SIGNATURE: J. W. Fagan M. D. or other

Address: Delmar Del Date signed 6-30-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-C)

CERTIFICATE OF DEATH

06450

★ Reg. Dist. No. 933

1. PLACE OF DEATH:

County: Wicomico Co.

City or town: Salisbury Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 days Infirm

Hospital, institution, or street address where death occurred:

E.S. D.B. Sanatorium

How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Wicomico

City or town: Salisbury

(If outside city or town limits, write RURAL and give nearest town)

Street No. 223 Race St

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Burley Jones

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Beulah Pollitt Jones

6.(c) If alive, give age: 56 years

7. Birth date of deceased (mo., day, yr.): July 27, 1893

8. AGE: Years	Months	Days	If less than one day
51	10	8	....hrs. ....min.

8. Birthplace: Salisbury Md (Town, county, and state)

10. Usual occupation: Truck driver

11. Industry or business:

FATHER 12. Name: Will Jones

13. Birthplace: Maryland

MOTHER 14. Maiden name: Vernie Littleton

15. Birthplace: Maryland

16. Informant: deceased on admission

Address:

17. Burial (Burial, cremation, or removal, Which?) Date thereof June 7-1945 (month) (day) (year)

Cemetery or crematory: Littleton Cemetery

Location: P.O. Salisbury Md (East Hill Road)

18. Funeral director: Hillman & Walter R. Hillman

Address: Salisbury Maryland

19. 6/7/45 (Date rec'd by registrar) Harriet E. Johnson (Registrar) Local

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 5 1945 at 9:10 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 5/20/45 19.. to 6/5/45 19.. and that I last saw him alive on 6/5/45 19..

Immediate cause of death	DURATION
Pulmonary Tuberculosis	unknown
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Paul Cohen M. D. or Other

Address: Salisbury Md Date signed: 6/5/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

CERTIFICATE OF DEATH

06451

Reg. Dist. No. 333

1. PLACE OF DEATH:

County Wicomico

City or town Fruitland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? all life

Hospital, institution, or street address where death occurred:
at Home, Fruitland, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Wicomico

City or town Fruitland
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war no

3.(a) FULL NAME Rose Marie Jones

3.(b) Social Security Number no

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	a a	baby

6.(b) Name of husband or wife no

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-1-45

8. AGE: Years	Months	Days	If less than one day
	3	20	hrs. min.

9. Birthplace Fruitland, Wicomico Co, Md.
(Town, county, and state)

10. Usual occupation no

11. Industry or business no

FATHER 12. Name Herbert Jones

13. Birthplace Scotland Neck, North Carolina

MOTHER 14. Maiden name Alma Neals

15. Birthplace Wendell, North Carolina

16. Informant Herbert Jones

Address Fruitland, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5-22-45 (month) (day) (year)

Cemetery or crematory Mt. Olivet Cemetery

Location Fruitland Maryland

16. Funeral director James F. Stewart

Address 402 E. Church St. Salisbury Md.

19. 5/24 (Date rec'd by registrar) 1945 Harriet D. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-22 1945 at 6 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ~~5-21~~ 19 to ~~5-22~~ 19
and that I last saw ~~him~~ her alive on ~~5-21~~ 5-22 19

Immediate cause of death	DURATION
Acute pulmonary Bronchopneumonia	12 hours
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations none

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: no

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Pat Rademacher M.D. Chief Medical Examiner, Wicomico Co.

Address Salisbury Md. Date signed 5/24/45

M. D. or other

M

MARGIN RESERVED FOR BINDING

1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

T

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (45-c)

CERTIFICATE OF DEATH

06452

Reg. Dist. No. 333

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 weeks

Hospital, Institution, or street address where death occurred:

Salisbury Peninsula General Hosp.

How long in hospital or institution? 2 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Worcester

City: Rural Pocomoke

(If outside city or town limits, write RURAL and give nearest town)

Street No. —

(If rural, give LOCATION)

2.(a) If veteran, name war — ✓

3. (a) FULL NAME Mr Snow Jones

3. (b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widowed

6.(b) Name of husband or wife: Ida. Jones.

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.): Nov. 28-1868

8. AGE:

Years	Months	Days	If less than one day
76	6	3	...hrs. ...min.

9. Birthplace: Pocomoke Worcester Md. (Town, county, and state)

10. Usual occupation: Farming

11. Industry or business: —

FATHER

12. Name: Isaac M. Jones

13. Birthplace: Md.

MOTHER

14. Maiden name: Susan W. Clavell

15. Birthplace: Md.

16. Informant: Lelia Jones

Address: Rural Pocomoke Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 5, 1945 (month) (day) (year)

Cemetery or crematory: Goodwill Cemetery

Location: Rural Pocomoke Md.

18. Funeral director: Margaretta E. Watson

Address: Pocomoke City Md.

19. 6/6/45 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 3 1945, at 7:18 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7/19 1945, to 6/3 1945

and that I last saw him alive on 6/3 1945

Immediate cause of death	DURATION
Carcinoma of Mouth	4 Mo.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R. M. Tuck M. D. or other

Address Salisbury Md. Date signed 6/4/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

06453

CERTIFICATE OF DEATH

Reg. Dist. No. 333

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 years
Hospital, Institution, or street address where death occurred: 105 Cherry street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. 105 Cherry St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Cora A. Kleinhenn
3.(b) Social Security Number:

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Widow
6.(b) Name of husband or wife: Arthur M. Kleinhenn
6.(c) If alive, give age: Dead years
7. Birth date of deceased (mo., day, yr.): Nov. 16 - 1870
8. AGE: Years: 74 Months: 6 Days: 26 If less than one day: hrs. min.
9. Birthplace: Defiance Ohio.
(Town, county, and state)
10. Usual occupation: Home life
11. Industry or business:
FATHER 12. Name: George Ashton
13. Birthplace: Defiance Ohio.
MOTHER 14. Maiden name: Brakefield
15. Birthplace: Defiance Ohio.
16. Informant: Mr. Jay M. Kleinhenn
Address: Bridgeville Delaware
17. Burial (Burial, cremation, or removal. Which?) Date thereof June 15-45 (month) (day) (year)
Cemetery or crematory: Parsons Cem.
Location: Salisbury Maryland
18. Funeral director: Holloway Bros. Walter R. Holloway
Address: Salisbury Md.
19. 6/16/45 (Date rec'd by registrar) Chas. E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 12 1945, at 11:30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 15 1945, to June 12 1945
and that I last saw her alive on June 12 1945

Immediate cause of death	OURATION
Chronic Interstitial Nephritis	?
Due to	
Due to	
Other conditions Chronic Myocarditis	?

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: H. E. Lecates M. D. or coroner
Address: Delmar Del. Date signed 6/17/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

06454

★ Reg. Dist. No. 337

1. PLACE OF DEATH:

County Wicomico

City or town Tyaskin
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Lifetime

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Wicomico

City or town Tyaskin
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war World War No. 1

3.(a) FULL NAME Charles Reed Larmore

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife Sylvia Larmore

6.(c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr.) May 22 - 1896

8. AGE: Years	Months	Days	If less than one day
49	-	18	...hrs. ...min.

9. Birthplace Tyaskin, Md.
(Town, county, and state)

10. Usual occupation Postmaster & farmer

11. Industry or business

FATHER 12. Name Charles Larmore

13. Birthplace Tyaskin, Md.

MOTHER 14. Maiden name Elizabeth Dorman

15. Birthplace Baltimore, Md.

16. Informant Mrs. Reed Larmore

Address Tyaskin, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 13, 1945 (month) (day) (year)

Cemetery or crematory cemetery

Location Tyaskin M. Church cem.

18. Funeral director C. B. Messick

Address Delmar Md

19. June 13 1945 (Date rec'd by registrar) R. Woolford Walter Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 10 1945, at 1.40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1st 1945, to June 9th 1945 and that I last saw h... alive on June 9 - 1945

Immediate cause of death	DURATION
Coronary Thrombosis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE William Emrich M. D. or other

Address Hebron Md. Date signed June 11-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15


JUIN 25 1945
BUREAU V.A.

Evidence for change of age of deceased is shown on FILM No. G 97 AUG 2 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

CERTIFICATE OF DEATH

06455

Reg. Dist. No. 333

1. PLACE OF DEATH:
County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: Peninsula General Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Delaware County Sussex
City or town Georgetown
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mr. William Layton

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	

6.(b) Name of husband or wife Sallie Wilson
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 16, 1862.

8. AGE: Years	Months	Days	If less than one day
~~83~~ 82	9 mo.	11	hrs. min.

9. Birthplace Delaware (Town, county, and state)
10. Usual occupation Retired Miller
11. Industry or business

FATHER
12. Name John Layton
13. Birthplace Delaware

MOTHER
14. Maiden name Mary Elizabeth Sammons
15. Birthplace Delaware

16. Informant John I. Carey - Mrs. Ida Ayres
Address Georgetown, Delaware

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6/29/45 (month) (day) (year)
Cemetery or crematory Barretts Chapel
Location Frederica, Delaware

18. Funeral director John I. Carey
Address Georgetown, Delaware

19. 6/28 (Date rec'd by registrar) 1945 Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 27 1945, at 3:45 P.M.

21. I CERTIFY, that death occurred on the date above stated; that I attended deceased from 6/18 1945, to 6/27 1945, and that I last saw him alive on June 27 1945

Immediate cause of death	DURATION
Hemiplegia	6 hrs
Due to Chr. Myocarditis	Indefinite
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations —
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE [illegible] M. D. or other
Address Salisbury Date signed 6/29/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

STATE OF MARYLAND—CERTIFICATE OF DEATH

06456

1. PLACE OF DEATH (157-g)

County Wicomico — Registration Dist. No. 293

Village or City Salisbury — No. Peninsula General St. — Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residanca in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U. S. if of foraign birth? ____ yrs. ____ mos. ____ ds.

2. FULL NAME Baby LeCates (not named) — If U. S. Veteran, specify WAR ____

(a) Residence: No. ____ Blades, Sussex St., Del. Ward. ____

(Usual place of abode) — If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word)
Male	White	

5a. If marriad, widowad, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day, and yaer) 6 - 4 - 1945

7. AGE	Yaers	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
			10	

OCCUPATION

8. Trade, profassion, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, atc. ____

9. Industry or businass in which work was done, as SILK MILL, SAW MILL, BANK, etc. ____

10. Date daceasad lest workad at this occupation (month and yeer) ____ — 11. Total time (yaars) spent in this occupation ____

12. BIRTHPLACE (city or town) Salisbury (Stete or country) Md

FATHER

13. NAME Robt. L. LeCates

14. BIRTHPLACE (city or town) Seaford (State or country) Del

MOTHER

15. MAIDEN NAME Kathleen Taylor

16. BIRTHPLACE (city or town) Seaford (Stete or country) Del

17. INFORMANT Mrs. Oliver Taylor (Address) Blades, Del

18. BURIAL, ~~CREMATION, OR REMOVAL~~ Place Blades, Del Date 6/17, 1945

19. UNDERTAKER Medford L. Watson Jr. (Address) Seaford, Del

20. FILED 6/16/45 Maggie E. Johnson Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH June 15, 1945 (Month) (Day) (Yeer)

22. I HEREBY CERTIFY, That I attendad decaasad from June 4, 1945, to June 15, 1945

I last saw him alive on June 15, 1945; death is said to hava occurrad on the data statad above, at ____ m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
Broncho-Pneumonia	
Other Contributory Causes of importance: Congenital Duodenal Atresia	

Name of oparation none Date of ____

What test confirmed diagnosis? Autopsy Was there an autopsy? yes

23. If death wes due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? none Date of injury ____, 19____

Where did injury occur? ____ (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury ____

Natura of injury ____

24. Was disaase or injury in any way related to occupation of deceasad? no

If so, specify ____

(Signed) H. Rives Hanson M. D.

(Address) Salisbury, Md.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

V. S. No. 1

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-a)

CERTIFICATE OF DEATH

06457

Reg. Dist. No. 393

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 25 years
Hospital, Institution, or street address where death occurred: 105 Perry St.
How long in hospital or institution? 1 year

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town)
Street No. 304 Kinder (If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Glenn Vance McCully

3. (b) Social Security Number: ✓

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: ✓
6.(c) If alive, give age: ✓ years

7. Birth date of deceased (mo., day, yr.): June 3, 1876.

8. AGE: Years 69 | Months 0 | Days 19 | If less than one day: hrs. min.

9. Birthplace: Tyrone, Penna. (Town, county, and state)

10. Usual occupation: Painter

11. Industry or business: ✓

FATHER
12. Name: Thirfield Scott McCully
13. Birthplace: Muney, Penna.

MOTHER
14. Maiden name: Martha Miller
15. Birthplace: Huntingdon, Penna.

16. Informant: Mrs. D. C. Treadupland
Address: Salisbury, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6/25/45 (month) (day) (year)
Cemetery or crematory: Philipsburg
Location: Philipsburg, Centre Co. Pa.

18. Funeral director: Pete Hill & Johnson Co.
Address: Salisbury, Md.

19. 6/24 (Date rec'd by registrar) 1945 Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 22 1945, at 11:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 18 1945, to June 22 1945 and that I last saw him alive on June 21 1945

Immediate cause of death	DURATION
Uremia	
Due to: Arteriosclerotic Cardiovascular Renal Disease	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Jno Graham M.D. M. D. or other
Address: Salisbury, Md. Date signed 6/24/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (940)

CERTIFICATE OF DEATH

06458

Reg. Dist. No. 333

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH: Wicomico

County: Wicomico

City or town: Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Lifetime

Hospital, institution, or street address where death occurred: R.D. #4 (Mt. Herman Road)

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Wicomico

City or town: Salisbury

(If outside city or town limits, write RURAL and give nearest town)

Street No. R.D. #4 (Mt. Herman Road)

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME John James Morris

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Ola Morris

6.(c) If alive, give age: 43 years

7. Birth date of deceased (mo., day, yr.): Sept. 19-1895

8. AGE: Years 49 | Months 8 | Days 29 | If less than one day: hrs. min.

9. Birthplace: Wicomico Co. Md (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: Own Farm

FATHER — 12. Name: Augustus Morris

FATHER — 13. Birthplace: Wic. Co. Md

MOTHER — 14. Maiden name: Cordelia Morris

MOTHER — 15. Birthplace: Wic. Co. Md.

16. Informant: Mrs. Ola Morris

Address: R.D. #4. Salisbury Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 21-45 (month) (day) (year)

Cemetery or crematory: Wic. Mem. Park

Location: Salisbury Maryland

18. Funeral director: Holloway & Walter R Holloway

Address: Salisbury Md.

19. 6/21/45 (Date rec'd by registrar) Harriet E Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 18th 1945 at 330P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 15 1945, to June 18 1945

and that I last saw him alive on June 18 1945

Immediate cause of death: Coronary Thrombosis — DURATION 6 d

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Hiram R Mann M. D. or other

Address: Salisbury Md Date signed 6/19/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (64-a)

CERTIFICATE OF DEATH

06459

Reg. Diat. No. 331

1. PLACE OF DEATH:

County: Wicomico

City or town: Quantico md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred: no

no

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Wicomico

City or town: Quantico md

(If outside city or town limits, write RURAL and give nearest town)

Street No.: no

(If rural, give LOCATION)

2.(a) If veteran, name war: no

3. (a) FULL NAME: Levin Morris

3. (b) Social Security Number: Last

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	a.a.	Single

6.(b) Name of husband or wife: no

6.(c) If alive, give age: no years

7. Birth date of deceased (mo., day, yr.): July 11 1927

8. AGE:

Years	Months	Days	If less than one day
17	11	30	hrs. min.

9. Birthplace: Quantico md (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Same as above

FATHER — 12. Name: Hayman Morris

13. Birthplace: Wilkinson Co Miss

MOTHER — 14. Maiden name: Mattie Weathers

15. Birthplace: Quantico Md

16. Informant: Hayman Morris

Address: Quantico md

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 17 1943 (month) (day) (year)

Cemetery or crematory: Quantico

Location: Quantico md

18. Funeral director: James T Stewart

Address: Salisbury Md

19. June 14 1945 (Date rec'd by registrar) Miss J M Waldo Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 11 1945, at 7.00 P. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 11 1945 to June 11 1945

and that I last saw h... alive on ... 19

Immediate cause of death: Suffocation — DURATION: sudden

Due to: Hanging

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Suicide Date of June 11 1945

Where did injury occur? Near Quantico (City or town) Wicomico (County) Md. (State)

Injured at home, farm, industry, public place (where?): Farm

Means of injury: Hanging Injured at work? no

23. SIGNATURE: Edward Fisher M.D.

Deputy Medical Examiner M. D. or other

Address: Salisbury Md Date signed: 6/11

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170-2)

CERTIFICATE OF DEATH

06460

Reg. Dist. No. 233

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 days
Hospital, Institution, or street address where death occurred: Penn Lee Hospital
How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Dorchester
City or town: Hambridge RFD 3
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: none ✓

3.(a) FULL NAME: Thomas E. Palmer

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 13, 1927

8. AGE: Years: 18 | Months: 2 | Days: 4 | If less than one day: hrs. min.

9. Birthplace: Cambridge (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business:

FATHER
12. Name: Emmett R. Palmer
13. Birthplace: Cambridge.

MOTHER
14. Maiden name: Ruth Fabro
15. Birthplace: Baltimore

16. Informant: Emmett R. Palmer
Address: Cambridge, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 19, 1945 (month) (day) (year)
Cemetery or crematory: Dorchester Memorial Park
Location: Cambridge, Md.

18. Funeral director: Kennett R. Thomas
Address: Cambridge, Md

19. 6/19/1945 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 17 1945, at 7.20 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h... alive on ..... 19.....

Immediate cause of death	DURATION
Fractured skull	2 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accident Date of: June 15 45
Where did injury occur? Rabbit Worcester Md
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Auto accident Injured at work? No

23. SIGNATURE: Chas L. Riley D.O. Med Exam M. D. or other
Address: Seaford, Del. Date signed: June 17 45

VS A15 (T) MARGIN RESERVED FOR BINDING (I) PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. (M)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31-C)

CERTIFICATE OF DEATH

06461

Reg. Dist. No. 333

1. PLACE OF DEATH
County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred E. S. Hosp.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother.)
State Md. County Wicomico
City or town Parsonsburg
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Guss Quinton Parsons

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Jennie E. Parsons
6.(c) If alive, give age 72 years
7. Birth date of deceased (mo., day, yr.) March 4-1865

8. AGE: Years	Months	Days	If less than one day
80	2	29	hrs. min.

9. Birthplace Parsonsburg Md.
(Town, county, and state)
10. Usual occupation Retired Farmer
11. Industry or business & Carpenter
FATHER 12. Name Daniel F. Parsons
13. Birthplace Parsonsburg Md.
MOTHER 14. Maiden name Elizabeth Jane
15. Birthplace
16. Informant Mr. Clifford F. Parsons
Address 14 Front Lane Salisbury
17. Burial (Burial, cremation, or removal. Which?) Date thereof June 6-45 (month) (day) (year)
Cemetery or crematory Parsonsburg Church Cem.
Location Parsonsburg Md.
18. Funeral director Hollowell & Walter K. Hollowell
Address Salisbury Md.
19. 6/6/45 (Date rec'd by registrar) Margaret E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 3rd 1945 8.25 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1945 to June 3 1945
and that I last saw h. alive on June 3 1945

Immediate cause of death	DURATION
Uremia	
Due to Arteriosclerosis C-V-R Disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

20a. SIGNATURE Jm Delaney M. D. or other
Address Salisbury Md Date signed 6/5/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-a)

CERTIFICATE OF DEATH

06462

Reg. Dist. No. 332

1. PLACE OF DEATH: Wicomico

County: Wicomico

City or town: Parsonsburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Lifetime

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infant, give residence of mother)

State: Md. County: Wicomico

City or town: Parsonsburg

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME William Wilson Parsons

3. (b) Social Security Number

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: Georgia Annie Parsons

6.(c) If alive, give age: Dead years

7. Birth date of deceased (mo., day, yr.): Nov. 21-1868

8. AGE: Years 76 | Months 6 | Days 20 | If less than one day: hrs. min.

9. Birthplace: Parsonsburg Md.
(Town, county, and state)

10. Usual occupation: Retired

11. Industry or business: Buck mason

FATHER 12. Name: Daniel James Parsons

FATHER 13. Birthplace: Parsonsburg Md

MOTHER 14. Maiden name: Maria Elizabeth Layfield

MOTHER 15. Birthplace: Parsonsburg Md.

16. Informant: Mrs. Martha Bounsend

Address: Parsonsburg Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 14-1945 (month) (day) (year)

Cemetery or crematory: Parsonsburg Church Cem

Location: Parsonsburg Md.

16. Funeral director: Holloway & Walter R. Holloway

Address: Salisbury Maryland

19. 6/14 1945 (Date rec'd by registrar) Lillian L. Davis Registrar Local

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 11th 1945 at 3:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1, 1945, to day of death, June 11, 1945 and that I last saw h. alive on June 11, 1945

	DURATION
Immediate cause of death: Myocardial chronic	yrs.
Due to: Chronic nephritis UREMIA	
Due to: Hypertension	
Due to: Arteriosclerosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Frank Lewis Sr. M.D. M. D. or other

Address: Pocomoke Md Date signed 6-12-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (117-a)

CERTIFICATE OF DEATH

06463

Reg. Dist. No. 333

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? One Day 18 years

Hospital, Institution, or street address where death occurred: Peninsula General Hospital

How long in hospital or institution? One Day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Wicomico

City or town: Salisbury md

(If outside city or town limits, write RURAL and give nearest town)

Street No. 903 Hill St

(If rural, give LOCATION)

2.(a) If veteran, name war: no

3.(a) FULL NAME: Willie Reid

3.(b) Social Security Number: Unk

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	C	Married

6.(b) Name of husband or wife: Belah Reid

6.(c) If alive, give age: ..... years (Not known)

7. Birth date of deceased (mo., day, yr.): — — about 1847

8. AGE: Years: about 98 Months: Days: If less than one day: ..... hrs. ..... min.

9. Birthplace: Bellehaven Va (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Same as above

FATHER

12. Name: Bynard Reid

13. Birthplace: Bellehaven Va

MOTHER

14. Maiden name: Judy Downing

15. Birthplace: Bellehaven Va

16. Informant: Belah Reid

Address: Salisbury Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 12 1945 (month) (day) (year)

Cemetery or crematory: Houston

Location: Salisbury Md

18. Funeral director: James A. Stewart

Address: Salisbury Md

19. 6/12, 1945 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 9 1945, at 2 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 9 1945 to June 9 1945

and that I last saw him alive on June 9 1945

	DURATION
Immediate cause of death: Ruptured Gastric Ulcer	
Due to: Chronic Myocard. Ds	
Due to: Pleurisy with Effusion	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: Salisbury Md Date signed 6-13-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06464

Reg. Dist. No. 333

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Peninsula General Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Wicomico

City or town: White Haven (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Olive Robertson

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Lawrence J. Robertson

6.(c) If alive, give age: 66 years

7. Birth date of deceased (mo., day, yr.): June 17-1882

8. AGE: Years: 62 Months: 11 Days: 15 If less than one day: hrs. min.

9. Birthplace: Nanticoke Md. (Town, county, and state)

10. Usual occupation: Home Wife

11. Industry or business: at Home

FATHER — 12. Name: Robert F. Young

FATHER — 13. Birthplace: Nanticoke Md.

MOTHER — 14. Maiden name: Mary R. Parker

MOTHER — 15. Birthplace: Nanticoke Md.

16. Informant: Lawrence J. Robertson

Address: White Haven Md.

17. (Burial, cremation, or removal. Which?) Buried Date thereof: June 5-45 (month) (day) (year)

Cemetery or crematory: Tyaskin Church Cem.

Location: Tyaskin Md.

18. Funeral director: C. Ellen Messick

Address: Birdsboro Maryland

19. 6/15 1945 (Date rec'd by registrar) Gabriel E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 2, 1945, at 4:59 M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 1 1945, to June 2 1945

and that I last saw h alive on 19

Immediate cause of death	DURATION
Coronary Thrombosis	5 hrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Dallas Dulin M. D. or other

Address: Nanticoke Md. Date signed: 6-4-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

06465

Reg. Dist. No. 333

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

RFD #2

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Wic.

City or town: Salisbury

(If outside city or town limits, write RURAL and give nearest town)

Street No.: RFD #2

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Irving Shockley

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 22 - 1944

8. AGE: Years	Months	Days	If less than one day
	10	23	hrs. min.

9. Birthplace: Salisbury Md (Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER — 12. Name: Geo. Shockley

13. Birthplace: Milford Del

MOTHER — 14. Maiden name: Gertrude Rounds

15. Birthplace: Salisbury, Md

16. Informant: Geo. Shockley

Address: Salisbury, Md.

17. Buried (Burial, cremation, or removal. Which?) Date thereof: 6-17-45 (mouth) (day) (year)

Cemetery or crematory: M.E.

Location: Delmar, Del

18. Funeral director: W.S. Hurd Co.

Address: Delmar, Del.

19. 6/16/45 (Date rec'd by registrar) Harriett E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 15 19 45, at 11 o M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 12 19 45, to June 15 19 45

and that I last saw h.i.m. alive on June 15 19 45

Immediate cause of death	DURATION
Broncho-Pneumonia	
Due to:	
Due to:	
Other conditions: none	

(Include pregnancy within 3 months of death)

Major findings of operations: none

Date of op.

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Rivers Hanson M.D. M. D. or other

Address: Salisbury, Md. Date signed: 6/16/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

CERTIFICATE OF DEATH

06466

Reg. Dist. No. 332

1. PLACE OF DEATH:

County: Wicomico

City or town: Parsonsburg Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, Institution, or street address where death occurred: no

How long in hospital or Institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Wicomico

City or town: Parsonsburg Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.: no

(If rural, give LOCATION)

2.(a) If veteran, name war: no

3. (a) FULL NAME: Paul W Smith

3. (b) Social Security Number: Not

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	a a	Married

6.(b) Name of husband or wife: Patty Smith

6.(c) If alive, give age: Years

7. Birth date of deceased (mo., day, yr.): Feb 6 1879

8. AGE: Years: 66 Months: Days: If less than one day: hrs. min.

9. Birthplace: Parsonsburg md (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: Same as above

FATHER — 12. Name: Daniel Smith

FATHER — 13. Birthplace: Parsonsburg Md

MOTHER — 14. Maiden name: Mahaley Dunkleson

MOTHER — 15. Birthplace: Parsonsburg Md

16. Informant: Mrs Adaline Smith

Address: Parsonsburg Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 19 1945 (month) (day) (year)

Cemetery or crematory: Glen Hill

Location: Parsonsburg Md

18. Funeral director: James R Stewart

Address: Salisbury Md

19. 6/19 1945 (Date rec'd by registrar) Clifton R Davis Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 16, 1945, at 1 35 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1, 1945, to June 16 1945 and that I last saw h alive on June 15, 1945

Immediate cause of death	DURATION
Cerebral Apoplexy	2 days
Due to: Chronic Myocarditis	1 yrs.
Due to: Hypertension	3 yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: G H Lemmon MD M. D. or other

Address: 501 E Church St Date signed: 6/18/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (56)

CERTIFICATE OF DEATH

06467

★ Reg. Dist. No. 333

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH: Wicomico

County ..... Wicomico

City or town Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 months

Hospital, institution or street address where death occurred:

P.H. Bevyt.

How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Wicomico

City or town Salisbury

(If outside city or town limits, write RURAL and give nearest town)

Street No. 213 Winder St.

(If rural, give LOCATION)

2.(a) If veteran, name war .....

3. (a) FULL NAME Eva D. Townsend

3. (b) Social Security Number .....

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	White	Married

6.(b) Name of husband or wife John B. Townsend

6.(c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) Feb. 9-1881

8. AGE: Years	Months	Days	If less than one day
64	4	8	..... hrs. ..... min.

9. Birthplace White Haven Md. (Town, county, and state)

10. Usual occupation Home Wife

11. Industry or business at Home

FATHER

12. Name William Phillips

13. Birthplace White Haven Md.

MOTHER

14. Maiden name Estella Price

15. Birthplace White Haven Md

16. Informant Mr. John B. Townsend

Address 213 Winder St. Salisbury Md.

17. Buried (Burial, cremation, or removal. Which?) Date thereof June 19-45 (month) (day) (year)

Cemetery or crematory Sloans Cem.

Location Sloans Maryland

18. Funeral director Wilmore & Walter R. Wilmore

Address Salisbury Maryland

19. 6/19/45 (Date rec'd by registrar) 19..... Laurie E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 17th 1945, at 2. P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 13 1945, to June 17 1945

and that I last saw h.. alive on June 17, 1945 19.....

Immediate cause of death	DURATION
Hepatic cirrhosis adenoma	
Jaundice	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Hepatic cirrhosis adenoma Jaundice Date of op. June 13, 1945

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Hugh A. Tinsley M. D. or other

Address Salisbury Md Date signed 6-18-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

96468

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 weeks
Hospital, institution, or street address where death occurred:
Salisbury Peninsula General Hosp.
How long in hospital or institution? 21 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Worcester
City or town: Rural Pocomoke
(If outside city or town limits, write RURAL and give nearest town)
Street No. —
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3.(a) FULL NAME Sadie E. Turner

3.(b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Widowed

6.(b) Name of husband or wife: Thomas Turner
6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): June 5 - 1878

8. AGE: Years: 67 | Months: 0 | Days: 5 | If less than one day: hrs. min.

9. Birthplace: Bridgetown Va.
(Town, county, and state)

10. Usual occupation: housewife

11. Industry or business: —

MOTHER
12. Name: Jacob Henry Church
13. Birthplace: Virginia

FATHER
14. Maiden name: Easter Ames
15. Birthplace: Virginia

16. Informant: William E. Turner
Address: Rural Pocomoke Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 13-1945 (month) (day) (year)
Cemetery or crematory: Unionville Cemetery
Location: Rural Pocomoke Md.

18. Funeral director: Margarette F. Webster
Address: Pocomoke Md.

19. 6/13/1945 (Date rec'd by registrar) Harriet E. Johnson Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 10 1945, at 5 10 P. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from May 22 1945, to June 10 1945
and that I last saw h.. alive on June 10 1945

Immediate cause of death	DURATION
Chronic myocarditis	6 mos.
with myocardial failure	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: none
Date of op.
Autopsy results: none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Jos Pedersen MD
Address: Salisbury Md M. D. or other
Date signed 6/10/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (73-A)

CERTIFICATE OF DEATH

06469

Reg. Dist. No. 333

1. PLACE OF DEATH:
County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
Peninsula General Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Worcester
City or town Snow Hill
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war ✓

3. (a) FULL NAME Walker, Laura Blotom

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	W	D

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec. 26 1876

8. AGE: Years	Months	Days	If less than one day
68			hrs. min.

9. Birthplace Modesttown, Accomack, Va.
(Town, county, and state)

10. Usual occupation none

11. Industry or business

FATHER
12. Name William Walsh
13. Birthplace Liverpool England

MOTHER
14. Maiden name Margaret Ann Ewell
15. Birthplace Modest Town Va

16. Informant Mrs. Carrow Chandler
Address Snow Hill, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 12, 1945 (month) (day) (year)
Cemetery or crematory Blotom Cem.
Location Blotom, Va.

18. Funeral director J. D. Johnson Inc.
Address Parksley, Va.

19. 6/12, 1945 (Date rec'd by Registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 10 1945, at 6 55 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 31 1945, to June 10 1945 and that I last saw h. alive on June 10 1945

Immediate cause of death	DURATION
Pernicious Anemia	
Due to	
Due to	
Other conditions Azotemia	

(Include pregnancy within 3 months of death)

Major findings of operations none Date of op.

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J. Rivers Hanson, M.D.
M. D. or other
Address Salisbury, Md. Date signed 6/10/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

1164711

Reg. Dist. No. 393

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 days
Hospital, institution, or street address where death occurred: Peninsula Gen. Hospital
How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Somer-
City or town: Princess Anne
(If outside city or town limits, write RURAL and give nearest town)
Street No. ✓
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Mr. James Warwick

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	single

6.(b) Name of husband or wife: —
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept. 15 - 1863

8. AGE: Years: 81 | Months: 8 | Days: 21 | If less than one day: hrs. min.

9. Birthplace: Md (Town, county, and state)

10. Usual occupation: retired farmer

11. Industry or business:

FATHER
12. Name: James Warwick
13. Birthplace: Md

MOTHER
14. Maiden name: Mary E Tull
15. Birthplace: Md

16. Informant: Miss Molly Brereton
Address: Princess Anne Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6/16/45 (month) (day) (year)

Cemetery or crematory: Westover

Location:

18. Funeral director: J. M. Smith
Address: Princess Anne

19. 6/14/45 (Date rec'd by registrar) Harriet E. Johnson Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 2 - 1945, at 3.50 p. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5/29 1945, to 6/2 1945, and that I last saw him alive on 6/2 1945.

	DURATION
Immediate cause of death: Coronary Occlusion	sudden
Due to: Chronic myocarditis	Several months
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

28. SIGNATURE: Chas. T. Fowler M. D. or other
Address: Salisbury Md. Date signed: 6/13/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH INDELIBLE INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 170-C

CERTIFICATE OF DEATH

06494

Reg. Dist. No. 760

1. PLACE OF DEATH:
County: Wicomico Pen. Gen. Hospital
City or town: Salisbury md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 24 min.
Hospital, Institution, or street address where death occurred:
Peninsula Gen. Hospital
How long in hospital or institution? 24 mins.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Somerset
City or town: Cokesbury Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: John Wilson

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 1887

8. AGE: Years: 58 | Months | Days | If less than one day: ..... hrs. ..... min.

9. Birthplace: unknown (Town, county, and state)
10. Usual occupation: laborer
11. Industry or business

FATHER
12. Name: unknown
13. Birthplace

MOTHER
14. Maiden name
15. Birthplace

16. Informant: James A. Cottman
Address: Salisbury md.

17. Disposition: Alms House (Burial, cremation, or removal. Which?) Date thereof: June 5, 1945 (month) (day) (year)
Cemetery or crematory
Location: West Princess Anne

18. Funeral director: James D. Dennis
Address: Princess Anne md.

19. Oct 27 1945 (Date rec'd by registrar) R. H. Johnson M.D. Registrar Per J.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 3 1945, at 12:36 a.m.

21. I CERTIFY that death occurred on the date above stated; ~~that I attended deceased from~~ ..... 19.. to ..... 19.. and that I last saw h.. alive on ..... 19..

Immediate cause of death	DURATION
Broken neck & other injuries	
Due to: Auto accident	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of
Where did injury occur? New Princess (City or town) Somerset (County) Md (State)
Injured at home, farm, industry, public place (where?): Public road
Means of injury: Struck by auto Injured at work? No

23. SIGNATURE: Dept. Medical Examiner Fred H. Crawford, M. D. M. D. or other
Address: Princess Anne Md. Date signed

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (9a)

CERTIFICATE OF DEATH

06471 ★

Reg. Diat. No. 329

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 13 years
Hospital, Institution, or street address where death occurred: On street Cor. Camden ave & Winder St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 116 W. Monticello ave
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Harvey Earl Wise

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Bertie Bonner Wise
6.(c) If alive, give age: 55 years

7. Birth date of deceased (mo., day, yr.): Oct. 2-1885

8. AGE: Years	Months	Days	If less than one day
59	8	22	....hrs. ....min.

9. Birthplace: accomac virginia (Town, county, and state)
10. Usual occupation: Crossing Watchman
11. Industry or business: P.R.R.Co.

FATHER
12. Name: John Leven Wise
13. Birthplace: accomac virginia

MOTHER
14. Maiden name: Margaret Ann Bunting
15. Birthplace: Laurelville Va.

16. Informant: Mrs. A. Bertie B. Wise
Address: 116 W. Monticello ave. Salisbury Md.

17. Burial (Burial, cremation, or removal, which?) Date thereof June 28 45 (month) (day) (year)
Cemetery or crematory: Mt. Holly Cem.
Location: Manoch Virginia
18. Funeral director: Holloway & Co. Walter R. Holloway
Address: Salisbury Maryland.

19. 6/27/45 (Date rec'd by registrar) Harriet E. Johnson Registrar Local

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 24 1945, at 6 20 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ....., 19...., to ....., 19.....
and that I last saw medical alive on ....., 19.....

Immediate cause of death: Coronary Thrombosis — DURATION: Sudden death

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: None — Date of op.:

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: J. A. Rademacher M.D. Deputy Med Examiner (M. D. or other)
Address: Salisbury Md. Date signed: 6/25/45

Evidence for the addition of color is shown on G 108

MARYLAND STATE DEPARTMENT OF HEALTH

1/29/47 2411 N. Charles St., Baltimore (83a)

CERTIFICATE OF DEATH

06472

★ Reg. Diat. No. 333

1. PLACE OF DEATH

County Wicomico

City or town Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Wicomico

City or town Salisbury

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Thomas Woodson

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	

6.(b) Name of husband or wife: Annie Woodson

6.(c) If alive, give age: 48 years

7. Birth date of deceased (mo., day, yr.): ? ? 1899

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
46	?	?		

8. Birthplace: ? ? South Carolina (Town, county, and state)

10. Usual occupation: Farmer + Saw Mill worker

11. Industry or business:

FATHER 12. Name: Unknown

FATHER 13. Birthplace: "

MOTHER 14. Maiden name: "

MOTHER 15. Birthplace: "

16. Informant: Annie Woodson

Address: Salisbury Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 6 1945 (month) (day) (year)

Cemetery or crematory: Asbury Cemetery

Location: Crisfield Md

18. Funeral director: John A Brodbraw

Address: Crisfield Md

19. 6/16/45 (Date recd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 6-14 19 45, at 5 25 M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 5-27 19 45, to 6-14 19 45; and that I last saw h[illegible] alive on 6-13 19 45

Immediate cause of death	DURATION
Apoplexy	
Due to Hypertension	2 mo. Estimated
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: E. P. Farnell M.D. M. D. or other

Address 210 W. Main Date signed 6-14-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15